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ABSTRACT

This document is a class presentation designed to present a history of child abuse and interventions for the beginning play therapist. Attempts to understand child behavior are traced back to their roots in the fields of mental retardation and special education as early as 1799 and followed through the mental health and child guidance movements of the early 20th century, the creation of the Society for the Prevention of Cruelty to Children in 1871, the emphasis on child protection during the 1909 White House Conference on Children, the enactment of the Child Abuse Prevention and Treatment Act of 1974, and the creation of the National Center on Child Abuse and Neglect. A number of factors that may mediate the impact of abuse on children are discussed and symptoms exhibited by children who have been victims of physical abuse, sexual abuse, neglect, emotional abuse, or ritual abuse are delineated. Nondirective play therapy is recommended as a counseling technique in working with these children. Therapists are encouraged to: (1) realistically remove from the child the responsibility and guilt of being victimized; (2) create an atmosphere where the child can feel safe and explore what is therapeutic for the child; and (3) help the child to develop a realistic plan to avoid future victimization. (NB)

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Abused and Traumatized Children

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Abstract

A class presentation designed to present a history of child abuse and interventions for the beginning play therapist.

Abused and Traumatized Children

Treatment of children in therapy is a relatively new concept in the mental health field. The child mental health movement appears to be a phenomenon of the twentieth century (Achenbach, 1974; Kanner, 1948). The first attempt to understand child behavior was not in the area of mental health, but rather in the area of mental retardation.

SPECIAL EDUCATION ROOTS

In 1799, Jean Itard was the first to attempt to educate the Wild Boy of Aveyron, who was thought to be raised by wolves. Itard thought that by teaching the Wild Boy of Aveyron to read, write and function in society, he could establish that nurture was greater than nature in the education process. Although Itard was only moderately successful in teaching the Wild Boy to function in society, he did establish methodology for teaching the mentally retarded. Edward Seguin in the

mid-1800s continued and expanded the work with the retarded by research into causes, nature, and treatment. (Achenbach, 1974). In the United States residential schools were built for the mentally retarded. In Massachusetts the first was built in 1848, followed by a second in New York in 1851. These facilities differed in that they were educational facilities rather than asylums. The initial goal was to train the retarded to function in society and then to return them to their homes. Although the theory of the "state school" was to develop functioning individuals, by the end of the nineteenth century, the school had become a custodial treatment facility (Morris & Kratochwill, 1983)

MENTAL HEALTH AND CHILD GUIDANCE MOVEMENT

Early in the twentieth century several concerns in mental health come to the forefront: the mental hygiene movement; child guidance clinics; and dynamic psychiatry. Clifford Beers published the book, A Mind That Found Itself in 1908. His book related his experiences while hospitalized for depression and suicidal tendencies. The

book described the maltreatment of patients in state mental hospitals. As the book was well read, the level of awareness of the deplorable state of mental health treatment came to the attention of many prominent professionals. The National Committee for Mental Hygiene was formed to provide information to the public concerning state hospital conditions, improved mental health treatment methods and to sponsor research on the prevention and treatment of mental illness. As an outgrowth of this mental health movement, mental hygiene programs began in schools and child guidance clinics were developed (Morris & Kratochwill, 1983).

In 1896, Lightner Witmer established the first child guidance clinic at the University of Pennsylvania preceding the publication of Beer's book. Beer's book provided the impetus of concern for mental health care, and in 1909 the Juvenile Psychopathic Institute was established in Chicago under the leadership of William Healy. The institute concentrated on studying juvenile offenders. Social Workers, psychologists, and psychiatrists worked together in an interdisciplinary

setting on particular cases, examining the multiple factors contributing to the child's behavior disorder(s). Aided by the National Committee For Mental Hygiene, about 500 child guidance clinics were established by 1930 (Morris & Katochwill, 1983).

PREVENTION OF CRUELTY TO CHILDREN

Another movement that took place during this period that may have affected the plight of children and their welfare was a movement against child abuse. Child abuse was considered to be a "family matter" and laws were not enacted to protect children until the late 1880s. Children were considered to be "property" of their parents; and furthermore, severe physical punishment was considered necessary. The Biblical phrase," spare the rod and spoil the child," was the justification of the treatment of children during this period. The first program to help abused children was organized in New York city in 1871 (Kempe & Kempe, 1978). The program was named The Society for the Prevention of Cruelty to Children after its predecessor, The Society for the Prevention of Cruelty to Animals. By 1880, 33 Societies

for the Prevention of Cruelty to Children were established in the United States; and 15, in other countries (Gordon, 1987).

By 1909 The White House Conference on Children that there was a vital part of child protection was to work with parents to prevent abuse and neglect from recurring. The 1940s brought some documentation of physical abuse appearing in hospital settings. Caffey was one of the first to write an article describing subdural hematomas in infants with atypical fractures of the limb and ribs (Gil, 1991). In 1962, Dr. C. Henry Kempe used the phrase "battered child syndrome," resulting in calling national attention to the plight of these children (Gil, 1991). By 1968, all fifty states enacted laws that required reporting of child abuse. In 1974 The Child Abuse Prevention and Treatment Act was signed into law and The National Center on Child Abuse and neglect was created (Morris & Katochwill, 1983).

MEDIATING THE IMPACT OF ABUSE

The impact of the abuse on the child depends on the following factors: age of the child at the time of the

occurrence, the regularity of the abuse, the severity, the relationship to the perpetrator, degree of threat to the child, level of family functioning, the child's mental and emotional health prior to abuse, amount of guilt carried by child, the sex of the victim and the parent's response to the child's victimization (Gil, 1991).

Because younger children experience less control of their fears, anger, and terror, the younger the child is the worse the abuse affects the child. More often the child experiences the abuse, the more severe the effects and affects of the abuse. In physical abuse the intensity or severity can result in a multitude of handicaps.

In sexual abuse, the severity is based on whether there has been penetration or not. In addition, the approach of the perpetrator is important. The question the therapist needs to know is the degree of seduction and/or brutality used in victimizing the child. The closer the relationship and the greater the threat, the worse the trauma is for the child.

Family dynamics play an important role in the impact of the abuse. A child in a functional family, who is abused by an outsider has better prognosis than a child from a dysfunctional family experiencing incest. Intervention becomes even more difficult when the abuse has been the norm for more than one generation. The child may actually suffer more from the chaotic and disorganization of the family than from the sexual or physical abuse (Gil, 1991).

The child's inter-strength at the time of the abuse is also important. Children who may be grieving the loss of a parent, through death, divorce, or separation are more vulnerable and more traumatized. Children in a secure family with support who are not blamed for their victimization have better recoveries than those who are blamed for the removal of a parent, blamed for their "misconduct," and other forms of guilt producing actions by significant adults. Even the investigation system can make the child feel he or she is to blame. The therapist must help the child to realize that he or she is a victim. A victim is not responsible for what happened to

them. Nonabusing significant adults form a successful barrier between the child and the victimization, if they are not accusatory, but supportive and reassuring (Gil, 1991).

The gender of the child makes a great deal of difference in the prognosis. Because the demands of society are different for boys than for girls, boys tend to have more serious problems and greater pathology (Gil, 1991).

SYMPTOMS OF ABUSE

Finkelhor (1986) found that children who have suffered sexual abuse often exhibit the following signs: fear or anxiety, depression difficulties in school, anger or hostility, inappropriate sexualized behavior, and running away or delinquency. In contrast, Martin (1976) found that physically abused children exhibited the following symptoms: impaired capacity to enjoy life, psychiatric symptoms, enuresis tantrums, hyperactivity, bizarre behavior, low self-esteem, learning problems in school, withdrawal, opposition, hypervigilance, compulsivity, and pseudomature behavior. In addition,

the physical evidence may be seen in death, brain damage, mental retardation, cerebral palsy, learning disabilities, and sensory deficits. Beware of the child who exhibits scratches, bruises, and cuts, but does not appear to be clumsy in the playroom.

In the playroom, the child may express: more fantasy aggression than other children in the drawings, storytelling, and psychodrama; exhibit aggressive behavior more frequently in his or her play themes; and express more fantasy aggression about their natural homes than foster care.

Neglected children were found by Polansky, Chalmers, Williams, and Buttenwieser (1981) to indicate neglect by the following behaviors: deprivation, detachment, regression of feelings, flattened affect, inability to empathize with others, violence, delinquency, and decrease in intellectual ability.

Emotional abuse as described by Garbarino, Guttmann, and Seeley (1986) is signaled by the following signs: anxiety, aggression, hostility, feelings of being unloved, unwanted, unworthy, negative view of the world,

irritability, somatic problems, anxious attachment to parents, fear, distrust, low self-esteem, feelings of inferiority, withdrawal, lack of communication, self-destructive behavior, caretaker to parents, and delinquency or truancy. Garbarino et al discuss that some children appear to be "stress-resistant" in that they become prosocial and competent in spite of their oppressive home life. These children are those who have had nurturance and support from outside the family.

Ritual abuse encompasses all forms of abuse and neglect: sexual, physical, and emotional. Accident proness is usually seen where the child may hurt himself or herself without any intention to do so. Acting out is another symptom in which the child may be attention seeking, violent, destructive or sexually curious and/or mature beyond expectation for age. The child may talk about animals in a preoccupied way that the animals are hurt or very scary. Body signs include balding, rectal or anal pain, strange facial grimacing, unusual bruises, vaginal pain, bleeding, lacerations, scarring, relaxed sphincter muscle, provocativeness, and discussions of

being wet or dirty. References to bondage or being caged are frequently reported by children who have been ritually abused. Children who have been ritually abused have cognitive problems as expressed in learning disabilities and unfocused, disorganized or even nonexistent play. Wearing costumes may be talked about by the child. Children may be report being made to take drugs and/or alcohol. Ritually abused children may have strange toilet habits, which include preoccupation with feces and urine, smearing feces on walls, strewing soiled toilet paper across floor, tasting, touching or swallowing urine and feces (Warnke, 1991).

Emotional symptoms include anger, anxiety, phobias, guild, apparent feelings of low self-esteem, rapid mood swings and separation anxiety from parents or significant other (this could include the therapist). The children may have unusual fears such as: being abducted by bad people, fear of the dark, fear of dying, fear of the genital area being washed, the house burning down, monsters, ghosts, mutilation, other children harmed, parents being killed or hurt, something foreign in the

body, and references to heart turning to ice. References to killing are not uncommonly seen in the play of a ritually abused child (Warnke, 1991)

The child may refer to photographs in the sense of movies being made, or photographs of nude children. Drawing by the child may depict ritual abuse, satanic symbols, monsters, ghosts, devils, penises, and naked men or women. References to places such as cemeteries, forests, caves, going to a different school, hospitals, or other unusual places are common among ritually abused children (Warnke, 1991).

The child may also exhibit changes in sleep patterns, speech habits, or make strange references. The sleep patterns will include nightmares and/or night terrors. The child may start to talk in a strange deep voice or develop a speech impediment (Those children who are not perfect are "precious" to Satan.)The strange references may be to another mother, daddy or family. Then the child may report sexual abuse much like any other child (Warnke, 1991).

It is important to know that ritual abuse, like

incest, may be part of the family history. There is an element of danger of working with these children, just as there is in working with any other unstable family. The fact is that the therapist is working with sexual abuse, physical abuse, emotional abuse and neglect and one treats the client accordingly. The ritual abuse label only makes it sound more exotic.

TREATMENT PLAN

The goal of therapy is corrective and reparative experiences for the child. A reparative approach allows the child to process the traumatic event so that it can be understood and the experience tolerated. The corrective approach provides the child with an atmosphere of safety, trust, and well-being. Generally, the child will gravitate toward a reparative condition, if allowed to play freely in a safe environment with a trusted adult. Nondirective play is recommended for these first sessions with rules kept to a minimum for the security of the child. Nondirective play therapy as described by Axline (1947) is recommended. Play with anatomically correct dolls are not recommended.

Some children may be experiencing "post-traumatic" play. They may have symptoms including: compulsive repetition, unconscious link between play and the traumatic event, literalness of play with simple defenses, failure to relieve anxiety, lag time between incident and trauma, and perservation in play activities (Terr, 1983).

Silvern and Kaersvang (1989) warn that it is not enough to use traditional play therapy as described by Axline (1947), which provides for the expression of traumatic events through symbolic expression. This warning against traditional interventions, like play therapy described by Axline (1947), conflicts with training in child therapy which believes that symbolic expression and insight relieves the stress effects of childhood trauma. Unlike most symbolic play, post traumatic play can be repeated over and over with no relief. When the play pattern is decidedly presented as a memory, the therapist helps the child to uncover the facts that conform with the actual events (Silvern & Kaersvang, 1989).

According to Silvern and Kaersvang (1989), telling what happened to a trusted person may have a function that cannot be achieved by reflection or repetitive thinking. However, post traumatic play can retraumatize and strengthen defenses, if some intervention is not made by the therapist (Silvern & Kaersvang, 1989). Victims sometimes relive the events as if they were occurring in the present (Silvern & Kaersvang, 1989) Without this direct interpretation, symbolic play can express conflict or defense with no resolution for the child (Silvern & Kaersvang, 1989).

Symptoms of posttraumatic play are varied. Lack of emotional response and verbal response is not unusual after a child witnesses violence. This lack of response should not be interpreted as a reason not to pursue the child's reactions (Silvern & Kaersvang, 1989). The child may exhibit "perfect" behavior to keep the shame of believing he/she is a bad person from becoming known. The exact opposite of "perfect behavior" may occur. The counselor may receive a referral from a teacher or a caseworker complaining about the child's behavior. The

child may not be able to admit a mistake and may blame others to guard against the pain of the event.

Terr (1983) noticed that these children may often engage in ritualized play such as doodling, telling stories, or making audiotapes of the repetitive material. Much of the ritual play will be done when the child believes that he or she is not being observed. The therapist may have to watch the child from an adjoining room to know that the event is being played out repeatedly. The repeated play is meant to get control over the situation, but does not seem to allow the cathexis needed.

The role of the therapist is that of a calm listener who can empathize and withstand the child victim's anger and anxiety reduces fear in the child (Silvern & Kaersvang, 1989). Silvern & Kaersvang (1989) criticize a therapist following an approach rigidly. A strict client-centered approach would not allow a person to question "trivial" material. Questioning may provide disorganized, trivial details. The most trivial detail often provides the cue to what is the worst and most

personal interpretations of the event by the child (Silvern & Kaersvang, 1989). Silvern & Kaersvang (1989) point out that it is important for the therapist to draw parallels between symbolic play and reality, making the trauma of the event explicit.

Art, mutual storytelling, puppet play (psychodrama), and play have all been used with a stop-start technique. The child begins the ritual or reenactment of the event. At each major point, the therapist stops the child and helps the child to see that he or she could not have avoided the situation and was not at fault. In what Terr (1983) has called denouement therapy, the therapist uses this stop-start technique, but also helps the child to see how the situation might be avoided in the future, where a realistic plan can be developed for escape of the situation. The therapist and child may have to go through this process many times before resolution is achieved.

SUMMARY

In working with children who have been victims, the therapist must do three things:

1. Realistically remove from the child the responsibility and guilt of being victimized.
2. Create an atmosphere where the child can feel safe and explore what is therapeutic for the child.
3. Help the child to develop a realistic plan to avoid future victimization.

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